

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2017	
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
F000	<p>INITIAL COMMENTS</p> <p>An unannounced complaint survey was conducted at this facility on January 6, 2017 and January 9, 2017. The deficiencies cited in this report are based on closed record reviews, staff interviews, and review of other facility documentation. The survey sample size was eight (8) including four (4) closed records. The facility census the first day of the survey was one hundred and sixty-six (166).</p> <p>Abbreviations/Definitions used in this report are as follows: NHA- Nursing Home Administrator; DON- Director of Nursing; ADON- Assistant Director of Nursing; NP- Nurse Practitioner; RN- Registered Nurse; LPN- Licensed Practical Nurse; CNA- Certified Nursing Assistant; CPR- Cardiopulmonary resuscitation; ADLs - Activities of Daily Living, such as bathing and dressing; Cognitively intact - Able to make own decisions; Dementia - Loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; MDS- Minimum Data Set- An assessment tool used to assess nursing home residents.</p>			F000			
F309 SS=D	<p>483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care</p>			F309	<p>Past noncompliance: no plan of correction required</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/20/2017

Any Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of the survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F309	<p>Continued From page 1 and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the residents' comprehensive assessment and plan of care.</p> <p>483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interviews, and a closed record review as well as a review of other facility documents, it was determined that the facility failed to ensure that R7 was appropriately transported to an outside appointment in a wheelchair with footrests to support his legs and feet and as a result R7 sustained abrasions and bruising to his toes. The deficient practice was evident for 1 (R7) out of 8 sampled residents. The deficiency is past noncompliance and was corrected on 11/18/16. Findings include:</p> <p>Review of R7's clinical record revealed: Minimum Data Set (MDS) completed on 9/16/16 documented R7 as cognitively intact requiring extensive assistance with most activities of daily living including transfers, locomotion on and off</p>			F309			

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F309	<p>Continued From page 2 the unit and used a wheelchair and a walker.</p> <p>MDS completed on 11/10/16 documented that the resident was moderately cognitively impaired and required the same assistance as stated above and utilized a wheelchair and walker.</p> <p>Occupational notes:</p> <p>Dates of service 11/9/16 to 11/15/16 - resident "continues to decline out of bed tolerance and sitting on the edge of the bed."</p> <p>R7 "presenting a decline in all functional tasks."</p> <p>Nursing progress note- 11/15/16 at 1:37 PM documented "writer received a phone call from aide that took resident to Dr. appointment and resident (R7) was shaking and drooling." R7 was sent to the emergency room. Both the family and the physician were notified.</p> <p>Emergency Department notes and Hospital Notes for 11/15/16 documented the following:</p> <p>Neurological exam findings included the "patient is not oriented x 3" R7 was oriented to person.</p> <p>Skin assessment documented that there was dried blood noted to toes with skin discoloration and nail beds. Bleeding controlled and R7 denied any pain at that time.</p> <p>There is a nurses note that there is an alleged report that R7 was "dragged in wheelchair by ambulance transportation in route to this facility "poor history received. Ripped socks noted."</p> <p>Primary admitting diagnosis to the hospital was Myocardial Infarction (Heart Attack).</p>	F309		

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F309	<p>Continued From page 3</p> <p>According to E6 (CNA) statement dated 11/16/16:</p> <p>E6 was assigned to transport R7 to the doctor's appointment on 11/15/16. E6 stated that she did note blood on R7's socks when getting back in the van to go from the doctor's office to the emergency room. E6 was clear that the van driver pushed R7 in the wheelchair from certain points to other points and he/she was responsible for pushing R7 at certain times during the trip.</p> <p>During an interview with the surveyor on 1/9/17 at 11:58 AM, E6 indicated that he/she went to the appointment with R7 on 11/15/16. The wheelchair did not have footrest. E6 indicated that R7 was able to keep his legs up when he/she pushed the resident in the wheelchair. E6 stated to the surveyor that when R7 was getting back into the van via the ramp E6 observed that R7 had holes in his/her socks which were not there before and adjusted the socks for the resident. In the emergency room E6 noticed some blood on R7's socks. E6 indicated that R7 was talking during the trip and appeared his/her usual self.</p> <p>On 1/9/17 at approximately 12: 50 PM the surveyor interviewed E2 (DON). E2 had acknowledged previously that the wheelchair used for transport did not have footrest and R7 did not have his/her own wheelchair. E2 indicated that staff had received inservice training on the proper way to transport residents safely in and out of the facility which included the use of footrests. The surveyor received copies of the training sign-in sheets.</p> <p>The above findings were discussed at the exit conference with E1 (NHA) and with E2 on 1/9/16</p>	F309		

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F309	<p>Continued From page 4 at approximately 2:30 PM.</p> <p>The facility implemented the following plan of correction:</p> <p>E6 received specific inservicing on 11/18/16 regarding the 11/15/16 incident and on general safety with transports/ transfers for appointments/ wheelchair leg rests safety.</p> <p>Nurses, CNAs and Transporters were all inserviced on 11/18/16 regarding transfers for appointments/wheelchairs leg rests safety/safety transports.</p>	F309			

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**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

JAN 28 2017

Page 1 of 4

NAME OF FACILITY: Atlantic Shores

DATE SURVEY COMPLETED: January 9, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	An unannounced complaint survey was conducted at this facility on 1/6/17 and 1/9/17. The deficiency contained in this report is based on staff interviews, a review of a clinical record and review of other facility documentation. The facility census the first day of the survey was 166. The survey sample size was 8. Regulations for Skilled and Intermediate Care Facilities	The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable law. The facility has achieved substantial compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements as of 3/11/17.	
3201.1	Scope		
3201.1.2	Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed January 9, 2017: F309.	Cross refer to plan of correction CMS 2567-L survey completed 1/9/17 for Federal Tags F309.	

Provider's Signature  Title Administrator Date 1/20/17



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DATE SURVEY COMPLETED: January 9, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
6.0	Services To Residents		
6.3.10	<p>The facility shall ensure that all licensed or certified direct care staff receive CPR certification and shall ensure that at least one staff person with current CPR certification is present in the facility during all shifts.</p> <p>This requirement is not met as evidenced by the following:</p> <p>Based on staff interviews, a clinical record review and a review of other facility documents, it was determined that the facility failed to ensure that E5 [CNA] who initially performed the Heimlich maneuver on R2 had a current CPR certification which includes Heimlich maneuver training. This deficient practice was evident for 1 out of 6 staff reviewed who responded to the incident. Findings include:</p> <p>Minimum Data Set completed 1/16/16 documented that R2's cognitive skills were severely impaired, had no issues with swallowing and was not on a mechanically altered diet or a therapeutic diet.</p> <p>Facility statements completed on 6/24/16 Revealed the following:</p> <p>On 6/24/16 at approximately 6:45 PM R2 was in the dining room and observed to be drooling from his/her mouth and turning blue. E5 who was in the dining area performed the Heimlich maneuver while the other CNA yelled for the nurse. The nurse came immediately from down the hall and took over doing the Heimlich maneuver and later CPR. A code "Blue" was called and 911 called.</p>	<p>A. All CNAs were in-serviced on the Heimlich Maneuver, and E5 provided a return demonstration directly following the event. E5 has completed CPR recertification effective 1/18/17.</p> <p>B. All current licensed and certified direct care staff will be audited to determine current CPR certification. Staff that are determined not to hold current CPR certification will be required to complete certification by March 11, 2017.</p> <p>C. All new hires will be required to show proof of certification at time of hire, and a copy placed in their personnel file. They will be required to update their certification biannually.</p> <p>D. The Human resource Director / Staff Development Coordinator will conduct monthly audits ensuring all licensed and certified direct care staff CPR certifications are up to date to ensure 100% compliance x 3. Following will be a quarterly audit with reports submitted to the QA Committee for review monthly.</p>	3/11/2017

Provider's Signature _____ Title _____ Date _____



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	<p>A timeline completed on 6/24/16 by E1 (NHA) showed the above information in more detail.</p> <p>R2's clinical record documented the following: A nursing entry dated 6/24/16 at 9:13 PM documented a recap of the earlier events. Notifications were made.</p> <p>During an interview with the surveyor on 1/9/17 at 9:10 AM, E2 (DON) stated that he/she did question E5 on 6/24/17 after the incident and asked for a return demonstration on the Heimlich maneuver which E5 was able to do correctly.</p> <p>The surveyor requested a copy E5's CPR card on 1/9/17 which showed that E5 was certified from 8/2011 to 8/2013 and did not have a current certification. E5 was not available for interview on 1/9/17.</p> <p>During an interview with surveyor on 1/9/17 at 2:50 PM, E4 (LPN) who works the 3:00 PM to 11:00 PM shift stated that he/she responded to the emergency in the dining room very quickly. E4 heard someone yelling for help and ran down the hallway immediately and took over doing the Heimlich maneuver and later started CPR. A code was immediately called and other personnel helped with the code. Staff called 911 and the paramedics arrived and took over the care of R2.</p> <p>On 1/9/17, the surveyor received a copy of E4's current CPR card which showed that it was issued 5/2015 and expires 5/2017.</p> <p>On 1/11/17 (post-survey) at approximately 2:00 PM the surveyor called E2 (DON) and</p>		

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	<p>requested he/she send copies of CPR cards for 4 other staff who responded to the code on 6/24/16. All were current at the time of the incident.</p> <p>The surveyor went over the above findings during the exit conference on 1/9/17 at approximately 2:30 PM.</p>		

Provider's Signature _____ Title _____ Date _____